daily, with gradual loss of weight, and foul drainage from wound, as well as fecal drainage from cecostomy.

On August 24, 1942, the patient returned to the Tulare County Hospital having moderate abdominal distention, with some tympany, but free fecal drainage from cecostomy wound. The operative wound was still draining purulent material. He was generally emaciated, and there were broncho-vesicular breath sounds at the left base posteriorly. His death from clinical pneumonia took place on August 28, 1942, just ninety days after his first admission.

Autopsy.—Performed at Tulare County Hospital, August 28, 1942. Aside from the general wasting, and the finding of a moderate degree of pneumonic process in both lungs, the most interesting information was observed in the abdominal cavity. The entire abdomen had been involved in a severe peritonitis which had caused adhesions of each loop of bowel to its neighbor, with fibrin present in all interstices. There were also several accumulations of yellow sero-purulent material both intraabdominally and in the abdominal wall itself, as well as extraperitoneally between the rectum and bladder. There was a mal-rotation of the colon, which had been partially corrected by surgery, the cecostomy being open, and no obstructive lesion appeared to remain anywhere. The mesentery of the ascending colon was fully as long as that of the transverse colon, allowing great mobility of the ascending colon. All other abdominal organs appeared normal, both externally and on cut section. The immediate cause of death was, therefore, generalized peritonitis with wound separation, and terminal pneumonia.

SUMMARY

1. The literature for the past decade on the subject of volvulus of the cecum has been reviewed in part.

2. The relationship of congenital mal-rotation, maldescent, and improper fixation of the cecum, has been discussed as an etiological factor in the occurrence of cecal volvulus.

3. A case is reported, which unfortunately terminated fatally, in spite of timely surgery.

4. The author is in complete agreement with the conclusions of Morris, and Wolfer, and others, that prompt recognition by careful history, roentgenograms made early, followed by early surgery, will give the only satisfactory results in such cases; and that cecostomy or exteriorization should be the method of choice in treating acute cases, reserving resection for patients whose general condition is very good.

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Oppenheim's Disease.—The describer of amyotonia congenita, Hermann Oppenheim, was also the author of important treatises on traumatic neuroses, neurology, brain tumors, myasthenic paralysis, and cerebral syphilis. He was a man of boundless energy, earnest and indomitable. By his keen interest in neurology, he not only created a successful career for himself in this field but made far-reaching advancements that left their impress upon modern neurological science.—Warner's *Calendar of Medical History.*

RUPTURE OF THE URETHRA, AND IMPASSABLE STRICTURE OF THE URETHRA*

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THESE two separate entities are considered together because they are alike in that there is (1) dissolution of continuity of the urethra, (2) there is retention of urine, and (3) the bulbomembranous urethra is usually the site of involvement. Because of these similarities, the same general plan of treatment applies to both.

It is important at the present time that the general practitioner should have a better grasp of the fundamentals of the treatment of these conditions because of the increasing number of urethral injuries incidental to the accelerated pace of industry and the hazards of war. Unfortunately, the medical student learns little of practical value about their management in medical school, and textbook descriptions are so involved and contradictory that he is left in a state of utter bewilderment. As a matter of fact, the management of these conditions is comparatively simple provided certain principles of treatment are understood and followed.

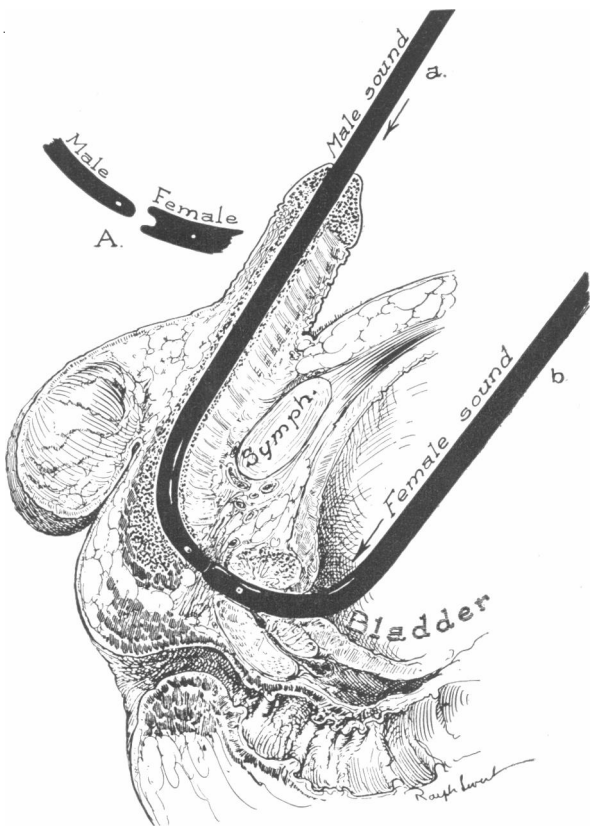

Fig. 1.—Drawing illustrating reëstablishment of continuity of urethra with Davis interlocking sound technique applicable both in rupture of the urethra and impassable stricture of the urethra. If stricture formation is so dense that sounds A and B cannot be approximated, the intervening scar tissue is excised through a small perineal incision. They are then approximated and A follows B on into the bladder. A catheter tied to A is drawn out through the urethra and left in place for permanent drainage and as a splint for healing.

* Read before the Section on Urology, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

RUPTURE OF THE URETHRA

Trauma to the urethra usually involves the bulbomembranous portion, sustained as a result of a blow to the perineum or falling astride some hard object, the so-called "straddle injury."

With rupture of the urethra and inability on the part of the patient to void, immediate treatment is imperative. If by gentle manipulation it is impossible to catheterize the patient, suprapubic cystotomy should be performed immediately. Cystotomy is the sheet anchor in the treatment of these cases as well as in impassable strictures. If the patient is in extremis, one should be content with cystostomy alone, and the second stage of the operation completed at a later date. Extravasation of urine and blood should of course be adequately drained by incisions of the involved areas at the first stage.

The second stage of the operation involves reëstablishment of the continuity of the urethra. The use of the Davis interlocking sounds (Fig. 1) provides the ideal solution of this problem. The female portion of the sound (b) is passed into the bladder through the cystotomy wound and guided into the prostatic urethra with the aid of the index finger until it meets the male sound (a) passed through the anterior urethra. The male sound is then passed easily on into the bladder, a catheter is tied to it and it is withdrawn, leaving the catheter in place for permanent drainage. The retention catheter is left in situ for about a week or ten days and then removed. Sounds are subsequently passed at intervals to preserve the urethral lumen and prevent stricture formation.

IMPASSABLE STRICTURE OF THE URETHRA

Strictures of the urethra are in general either (1) traumatic in origin, or (2) inflammatory. Most inflammatory strictures are of gonorrheal origin. Practically all impassable strictures, whether traumatic or inflammatory in origin, are located in the bulbomembranous urethra. Strictures of the urethra which cannot be dilated satisfactorily with sounds but which permit the passage of filiforms and followers to the bladder may be cut with the urethrotome (internal urethrotomy). Impassable strictures are best treated with the Davis interlocking sound technique exactly as described above for rupture of the urethra. In many cases, the strictured area may be so resistant that the interlocking sounds cannot be readily approximated. In that event, the following procedure is carried out: The patient is placed in lithotomy position and both the suprapubic and perineal regions are surgically prepared. The Davis interlocking sounds are approximated as nearly as possible and held in place by an assistant. The surgeon then can readily palpate the end of each sound through the perineum. The ends may be one to three centimeters apart as a result of the dense intervening urethral stricture. A small midline perineal incision is made between the ends of the sounds and the strictured area excised, thus permitting the two sounds to come together. The operation is then completed as described above for rupture of the urethra. A retention catheter is drawn in place through the urethra and permanent drainage maintained for ten days or two weeks. No sutures are necessary to approximate the severed ends of the urethral mucosa. Nature amply provides the necessary union about the catheter as a guide.

Considerable practical experience with this procedure has given convincing proof of its value as compared with the tedious and difficult perineal dissections that have hitherto been made in attempts to restore the continuity of the urethra.

CONCLUSIONS

A simple procedure applicable alike to the treatment of rupture of the urethra, and impassable stricture of the urethra, is described which practical experience has shown to be highly successful. These remarks may be interpreted as a testimonial to the Davis interlocking sounds, and rightly so, because they have brought order out of chaos and make it possible for the general practitioner as well as the specialist to manage these hitherto difficult cases with greater ease and success with a consequent reduction in morbidity and mortality rates.

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A PSYCHIATRIST-AT-LARGE IN JAPAN*

Z. M. L.
Japan

ON a recent trip to Tokyo, about a month after the occupation, I had an unusual opportunity to visit a Japanese medical school and teaching hospital. Our interpreter and guide was an excessively polite and immature looking college student named Taro. He had agreed to take us to Keio University Medical School where his cousin was in his third year. Keio University houses one of the seven large medical schools in Tokyo and is located in a section called Yotsuya, about five miles from the center of the city in a semi-residential district.

As we entered the grounds we noticed that many of the buildings had been damaged or destroyed. We were later informed that a third of their buildings, including the section for first class patients had been burned to the ground. Another third was seriously damaged and the remaining third was untouched. We were ushered into the library building, a memorial to one of their distinguished alumni, and introduced to Dr. S. Uiematsu, Professor of Neurology and Psychiatry and a graduate of Harvard University Medical School, class of 1922. It was shortly after twelve noon and the faculty was just finishing lunch in a large conference room, richly paneled in dark wood. Professor Uiematsu introduced us to the rest of the faculty and apologized for the absence of the dean who was out of the city. He showed us to chairs in an adjoining reception room and invited us to have luncheon. Being aware of the serious food shortage in Japan we declined his hospitable gesture, but he called for a pot of Japanese tea in which we all joined. In turn we offered him some American cigarettes which he smoked with obvious relish.

The professor was a small, serious man of about 50 years, with a tiny moustache and greying hair. He wore the conventional thick glasses and was dressed in a conservative tweed of American cut. His English was a bit slow and soft spoken, but his choice of words was exact. He spoke of his psychiatric training under the late Dr. Macfie Campbell with more than a trace of nostalgia. He looked rather subdued and sad as if to imply that the happenings of the last ten years were not of his choosing. He was very dignified, attentive, and polite to us as visitors, but there was none of the fawning and obsequious behavior which appears to be so prevalent among the conquered Nazis. We talked as colleagues and he answered all questions willingly and apparently without reserve.

We spoke first of psychiatry. He told us that the Japanese psychiatrists had anticipated a large number of psychiatric casualties following the B-29 bombing raids. They received only one-half the estimated number among the civilian population. (This is strikingly similar to the British experience as reported by Col. Gillespie.) There

* The letter that follows was received by CALIFORNIA AND WESTERN MEDICINE from a friend in the U. S. Navy. Its interesting observations explain its appearance in this department.—Ed.